Facesheet: 1. Request Information (1 of 2)

A. The **State** of **Texas** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

B. Name of Waiver Program(s): Please list each program name the waiver authorizes.

Short title (nickname)	Long title	Type of Program	
TMWP	Texas Medicaid Wellness Program	PCCM;	

Waiver Application Title (*optional - this title will be used to locate this waiver in the finder*):
Texas Medicaid Wellness Program

C. Type of Request. This is an:

☑ **Amendment request for an existing waiver.**
The amendment modifies (Sect/Part):
Section A Part I, Section A Part II, and Section D Part I.

Requested Approval Period:*(For waivers requesting three, four, or five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **1 year** ◉ **2 years** ○ **3 years** ○ **4 years** ○ **5 years**

Draft ID:TX.051.02.02
Waiver Number:TX.0022.R02.02

D. Effective Dates: This amendment is requested for a period of 2 years. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)
Approved Effective Date of Base Waiver being Amended: 04/01/16
Proposed Effective Date: *(mm/dd/yy)*
12/14/16
Approved Effective Date: 01/13/17

Facesheet: 2. State Contact(s) (2 of 2)

E. State Contact: The state contact person for this waiver is below:

Name: Kathi Montalbano
Phone: (512) 730-7409 **Ext:** ☐ **TTY**
Fax: (512) 487-3403 **E-mail:** kathi.montalbano@hhsc.s

If the State contact information is different for any of the authorized programs, please check the program name below and provide the contact information.
The State contact information is different for the following programs:

☐ **Texas Medicaid Wellness Program**

Note: If no programs appear in this list, please define the programs authorized by this waiver on the first page of the

Section A: Program Description

Part I: Program Overview

Tribal consultation.

For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.
HHSC submitted letters on June 24, 2015, to the three federally recognized tribal organizations to provide notification of the intent to submit a TMWP waiver renewal application and that the waiver renewal provided for the continuation of the TMWP with no changes to the existing program. The letter also informed them of the approved temporary extension of the current TMWP through November 31, 2015. HHSC received no comments or questions from the tribal organizations regarding the renewal application. Public notice of intent was posted to the Texas Register on July 10, 2015.

For this amendment, HHSC submitted letters on July 1, 2016 to the three federally recognized tribal organizations to provide notification of the intent to submit a TMWP waiver amendment and that the waiver amendment provides for the transition of 92 percent of the TMWP eligible pool and clients served to STAR Kids .Kids.

For this amendment, HHSC submitted letters on October 17, 2016, to the four federally recognized tribal organizations to provide notification of the intent to submit a TMWP waiver amendment. The notice explained that the waiver amendment proposes the addition of children and young adults in the Adoption Assistance (AA) and Permanency Care Assistance (PCA) population to TMWP, allowing these individuals access to TMWP services, The amendment also proposes the transition of dually eligible (Medicare and Medicaid) children and young adults who are in Department of Family and Protective Services (DFPS) conservatorship (foster care) and who currently get Medicaid fee-for-service, to STAR Health, the state's managed care program for children in DFPS conservatorship. The transition to STAR Health will affect only four individuals, all of whom have Medicare because of chronic health conditions such as chronic renal disease. These individuals will receive service management and additional supports, including access to the Health passport, through STAR Health.

Program History.
For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).
For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).
On March 1, 2011, HHSC launched the TMWP. The TMWP replaced the Texas Medicaid Enhanced Care Program, the previous Medicaid disease management program, which provided disease management services from September 2005 through February 2011. Through the TMWP, eligible traditional Medicaid clients in fee-for-service (FFS) and Primary Care Case Management (PCCM) had access to a care management service, which supported a whole person approach to addressing an individual's health needs and challenges. Unlike the Texas Medicaid Enhanced Care Program, which focused on five common chronic diseases (asthma, coronary artery disease, chronic obstructive pulmonary disease (COPD), heart failure, and diabetes), any chronic condition or cost-driving utilization pattern qualified clients for active engagement in the TMWP.

Program period one (PP1) of the TMWP covered the operational period from March 1, 2011 through February 29, 2012. This was also the program period for the Diabetes Self-Management Training Program (Diabetes Program) pilot for Texas Medicaid, which operated for one year. At the beginning of PP1, the TMWP made outreach attempts to more than 9,000 Texas Medicaid Enhanced Care Program clients eligible to transition into the new TMWP. HHSC identified additional individuals eligible for the TMWP through predictive modeling using the new program identification criteria. Outreach was then conducted to engage these newly eligible high-cost/high-risk clients with emerging chronic conditions and deteriorating health. As a result of these significant outreach and engagement efforts in PP1, the TMWP reached a high of 9,320 actively managed clients in one month (February 2012) and completed 14,991 client health assessments and 3,184 care team member visits to provider offices in the first year.

In the first few months of PP1, HHSC announced that PCCM would be eliminated and the majority of Medicaid adults would transition to mandatory managed care. HHSC made the decision to continue the TMWP for fee-for-service (FFS) clients who were not required to transition into managed care. The majority of this population included Supplemental Security Income (SSI) recipients under 21 years old and the rest of this population was comprised of other Medicaid eligible adults and children who remained in fee-for-service.

Effective March 1, 2014, an amendment added fee-for-service individuals under the age of 21 eligible for both Medicare and Medicaid (dual eligible) to participate in TMWP, including those in Department of Family and Protective Services (DFPS) conservatorship. Dual eligible children in DFPS conservatorship are ineligible for STAR Health (the service delivery plan for most children in DFPS conservatorship) and remain in fee-for-service. The amendment also changed the TMWP delivery system from a Prepaid Ambulatory Health Plan (PAHP) to a PCCM and FFS Selective Contracting system at the direction of CMS.

In June 2015, the TMWP contractor, McKesson, was acquired by AxisPoint Health (APH). HHSC updated the TMWP contract accordingly.

Effective November 1, 2016 HHSC is proposing to transition all Supplemental Security Income (SSI) recipients under 21 years old and fee-for-service individuals under the age of 21 eligible for both Medicare and Medicaid (dual eligible) to STAR Kids. HHSC is requesting that this populations be excluded from TMWP since the members will be receiving case management services from their Managed Care providers.

Throughout the history of TMWP the following initiatives were started and their successful implementation signifies major program milestones.

- The implementation of the Innovative Funds project at various clinics.
The purpose of the project is to improve TMWP clinical, compliance, and financial outcomes, as well as provider engagement and member satisfaction. The Innovative Funds program provides onsite placement of dedicated Community-

Based Primary Nurses (CBPNs) at high volume clinics to assist with coordination of care for eligible TMWP clients. The program currently includes the following sites:
•Texas Children's Hospital (TCH) Special Needs, Resident's Clinic and Progressive Care Unit (PCU) in Houston
•South Texas Center for Pediatric Care in San Antonio
•Chosen Clinic and Dr. Sanchez Behavioral Health Clinic in Houston and San Antonio
•Children's Hospital of San Antonio

From February 4, 2014, to October 31, 2015, a total of 2,594 clients have been seen at all of the Innovative Funds project clinics.

- Active engagement across the state with providers and key stakeholders. Provider engagement initiatives include the Patient-Centered Medical Home (PCMH) project with learning collaborations and webinars about improving access, appointment attendance and support of medical home transformation within the practices. Currently eight practices are engaged in pursuing PCMH certification and one practice achieving Level 1 PCMH certification. The TMWP Program Advisory Board is actively engaged in the PCMH project. The Program Advisory Board meetings were recently enhanced to include break-out sessions for members to discuss program topics, ideas for program improvements, best practices for outreach strategies, and improvements to adherence in evidence-based guidelines and closing gaps in care.

- TMWP clinical results, financial results, client satisfaction survey results and Quality of Life (SF-10) survey results continue trending positively each program year.

- Collaborative Initiatives including TWMP overview meetings with broader HHSC audience including Early Childhood Intervention, Department of Family and Protective Services, HHSC Quality and Contract Management, Medicaid/CHIP Division, Department of State Health Services and outreach initiatives with Medicaid Electronic Health Information Exchange System (MEHIS) and HHSC Electronic Prescriptions for Controlled Substances (EPCS).

- Enhanced Care Coordination meetings to review subsets of the TMWP population for greater focus on improving disease specific care coordination and clinical outcomes in collaboration with HHSC.

- TMWP enhanced the Weight Watchers Program to include additional follow-up with clients participating in the program, chart audits, and outcomes analysis to measure results and identify opportunities for program improvements.

Texas requests to continue this waiver, with the change to exclude the STAR Kids members transitioning into Managed Care as of November 1, 2016 from the TMWP proposed amendment.

Texas requests to continue this waiver, with the changes to add to the Wellness Program children previously in the care of the Department Family Protective Services (DFPS) who have been adopted or who are in permanent placements, and who now receive Adoption Assistance (AA) or Permanency Care Assistance (PCA) Medicaid.

HHSC is also proposing to remove from the Wellness Program the dually eligible (Medicare and Medicaid) children and young adults who are in DFPS conservatorship (foster care) and who currently get Medicaid fee-for-service. These individuals have Medicare because of chronic health conditions such as chronic renal disease. These individuals will receive service management and additional supports, including access to the Health Passport, through STAR Health.

With the transition of the majority of Medicaid clients whom have SSI and are under the age of 21 moving to STAR Kids, the eligible population will drop from an estimated 144,000 eligible members to an estimated 4,900 members. By adding the AA and PCA members the eligible population increases to 55,500. With the decrease of total eligible members HHSC is proposing to reduce the maximum members served from 12,000 to 6,590 per month per quarter.

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (1 of 3)

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):
   - **a.** ☑ **1915(b)(1)** - The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
     -- *Specify Program Instance(s) applicable to this authority*
     ☑ **TMWP**
   - **b.** ☐ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
     -- *Specify Program Instance(s) applicable to this authority*
     ☐ **TMWP**
   - **c.** ☐ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
     -- *Specify Program Instance(s) applicable to this authority*
     ☐ **TMWP**
   - **d.** ☑ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).
     -- *Specify Program Instance(s) applicable to this authority*
     ☑ **TMWP**

     The 1915(b)(4) waiver applies to the following programs
     - ☐ **MCO**
     - ☐ **PIHP**
     - ☐ **PAHP**
     - ☑ **PCCM** (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
     - ☑ **FFS** Selective Contracting program

       Please describe:
       The State has one vendor who delivers the training and education to individuals who choose to participate in this waiver. The vendor is paid a fee for each individual participating in the waiver. TMWP services are available to Medicaid beneficiaries who receive medical services through Medicaid FFS; are able, or have a caregiver who is able, to respond actively to health information and care coordination activities; and who are identified by HHSC and the TMWP contractor as being high-cost and/or high-risk due to chronic illness or condition. The TMWP contractor receives a per- member-per-month fee for enrollees who opt-in to waiver services, which does not include a component for medical claims. TMWP enrollees receive medical services under the traditional FFS Medicaid program, and not under the waiver itself. At the direction of CMS during the last renewal

application, HHSC changed the TMWP delivery system from a Prepaid Ambulatory Health Plan (PAHP) to a PCCM and FFS Selective Contracting system.

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (2 of 3)

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

   a. ☐ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
   -- *Specify Program Instance(s) applicable to this statute*
   ☐ **TMWP**

   b. ☑ **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.
   -- *Specify Program Instance(s) applicable to this statute*
   ☑ **TMWP**

   c. ☑ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.
   -- *Specify Program Instance(s) applicable to this statute*
   ☑ **TMWP**

   d. ☐ **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).
   -- *Specify Program Instance(s) applicable to this statute*
   ☐ **TMWP**

   e. ☐ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.
   -- *Specify Program Instance(s) applicable to this statute*
   ☐ **TMWP**

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:
HHSC is proposing to add to the Wellness Program children previously in the care of the DFPS who have been adopted or who are in permanent placements, and who now receive AA or PCA Medicaid; and to remove dually eligible (Medicare and Medicaid) children and young adults who are in DFPS conservatorship (Foster care) and who currently get Medicaid fee-for-service. The dually eligible individuals will receive service management and additional support through STAR Health. Due to these changes in the population, HHSC is proposing to reduce the total members served per month per quarter from 12,000 to 6,590.

HHSC is proposing to exclude the STAR Kids population transitioning into Managed Care on November 1, 2016 from the TMWP being proposed in this amendment. A PCCM will deliver services on a per member per month (PMPM) fee basis for education and training about health conditions and will not deliver a medical service to the remaining fee-for-service population. The PCCM will not be responsible for building a provider network, as waiver enrollees will continue to access Medicaid State Plan medical services through the Fee-for-Service Program.

Finally, HHSC is proposing to lower the guaranteed minimum net savings from 5% to 3.6%. The guaranteed minimum net savings is defined as an HHSC established baseline trended to the measurement year to project expected cost for the population. .Should the net savings as a percent of expected costs fall below the guarantee, then the payback will be proportional to (payback = (reconciled fees) * (percent of fees at risk for net savings) * [1-(actual net savings%/3.6%)]

The TMWP identifies enrollees who will benefit from services; tailors interventions to better meet an enrollee's needs; encourages provider input in care plan development; and applies clinical evidence-based practice protocols to the individual's care. The TMWP, using the principles of E.H. Wagner and the Chronic Care Model, focuses on three main components:
client self-management,
provider practice/delivery system design, and
technological support.

Under client self-management, an enrollee becomes an informed and active participant in the management of his or her physical and mental health conditions and co-morbidities. Under the provider practice/delivery system design approach, medical home providers take an active role in helping enrollees make informed healthcare decisions.

Waiver benefits are available statewide. An individual enrolled in the Medicaid FFS Program who is identified as high-cost and/or high risk using a State-approved predictive modeling system is eligible for the TMWP. This predictive modeling software analyzes medical claims data (e.g. emergency room, inpatient admissions, prescriptions, durable medical equipment, etc.) and assigns risk and impactability scores to identify potential enrollees for waiver services. If an individual is receiving medical services through managed care, he or she is not eligible for this waiver as he or she will already be receiving comparable case management services through the managed care system.

A contracted health management vendor functions as a PCCM. The State issued a competitive procurement, and entered into a contract with the currently selected PCCM. The PCCM works with the TMWP staff to create and maintain an innovative and effective program. The PCCM helps HHSC accomplish the following objectives:
develop an innovative and comprehensive approach to health management;
create a flexible and customer-oriented program;
identify and engage enrollees, through a predictive modeling system, with high cost utilizations and/or those who are at risk of becoming unstable or developing a serious chronic condition;
increase enrollees' skills, knowledge and confidence in self-managing their health conditions;
encourage providers to evolve their practices by becoming advocates of patient self-management and promoters of clinically evidence-based interventions;
utilize technology in supporting individual and provider goals; and
reduce duplicative Medicaid costs to the State.

The State pays the PCCM on a per-member-per-month basis for all TMWP enrollees corresponding with three levels of care and case management intervention. Individuals will not be considered enrolled until he or she has completed a health risk assessment and care plan. Depending on the care plan results, the enrollee will receive high intervention (Level 1), medium intervention (Level 2) or maintenance level intervention (Level 3). The PCCM only receives the per-member-per-month fee for enrollees who have opted-in to receive TMWP services.

The per-member-per-month fee does not include a component for medical claims. Medical claims for TMWP enrollees are paid under the traditional Medicaid FFS structure as described in the State Plan. Twenty percent of the fees paid to the PCCM for the TMWP are recouped based on the PCCM's ability to achieve targeted savings and performance measures. The State has the ability to assess contractual remedies, including monetary damages, if the PCCM fails to satisfy its contractual obligations.

Of the twenty percent of total fees that can be recouped, fifty percent of these fees are attributed to clinical quality measures, ten percent are attributed to humanistic measures (client surveys), and 40% are attributed to achieving a guaranteed minimum net savings.

In addition to achieving the guaranteed minimum net savings target, the PCCM is required to meet targets on enrollee's functional status surveys, and clinical and programmatic outcomes measures. In cases where the PCCM does not meet set

targets for these measures, proportional reimbursement will also be required.

By providing training and education to individuals on how to manage their condition/disease the State saves money by not incurring additional medical expenditures.

The State will return the federal share of any recoupments.

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (1 of 3)

1. **Delivery Systems.** The State will be using the following systems to deliver services:

   a. ☐ **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

   b. ☐ **PIHP:** Prepaid Inpatient Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

   ○ **The PIHP is paid on a risk basis**

   ○ **The PIHP is paid on a non-risk basis**

   c. ☐ **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

   ○ **The PAHP is paid on a risk basis**

   ○ **The PAHP is paid on a non-risk basis**

   d. ☑ **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

   e. ☑ **Fee-for-service (FFS) selective contracting:** State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards.

   ○ **the same as stipulated in the state plan**

   ◉ **different than stipulated in the state plan**

   Please describe:

   TMWP services are available to Medicaid beneficiaries who receive medical services through Medicaid FFS; are able, or have a caregiver who is able, to respond actively to health information and care coordination activities; and who are identified by HHSC and the TMWP contractor as being high-cost and/or high-risk due to chronic illness or condition. The TMWP contractor receives a per-member-per-month fee for enrollees who opt-in to waiver services, which does not include a component for medical claims. TMWP enrollees receive medical services under the traditional FFS Medicaid program, and not under the waiver itself. At the direction of CMS during the last renewal application, HHSC changed the TMWP delivery system from a Prepaid Ambulatory Health Plan (PAHP) to a PCCM and FFS Selective

Contracting system.

HHSC evaluated the proposals based on the following best value criteria.

A. Ability to achieve HHSC's mission and objectives, including the degree to which the proposal:
• achieves and communicates a clear understanding of HHSC's missions and objectives;
• includes a well-reasoned approach to fulfilling the program's requirements; and meets the needs of HHSC, and TMWP clients and providers.
B. The degree to which the proposal demonstrates program innovation, adaptability and exceptional customer service.
C. The respondent's demonstrated competence and qualifications, including:
• knowledge of health management through experience with Medicaid and/or vulnerable populations;
• knowledge of the Texas health care environment, including Medicaid providers and clients;
• expertise in medical practice facilitation;
• skills and abilities of key personnel related to the goals of the TMWP;
• reporting, evaluation design, and expertise; and
• respondent's organizational capacity.
D. The total program cost, including:
• the respondent's ability to fulfill all contract requirements at an acceptable cost; and respondent's ability to produce cost savings for the State of Texas.

f. ☐ **Other:** (Please provide a brief narrative description of the model.)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (2 of 3)

2. **Procurement.** The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

☐ **Procurement for MCO**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☐ **Procurement for PIHP**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☐ **Procurement for PAHP**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☑ **Procurement for PCCM**

- ◉ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☑ **Procurement for FFS**

- ◉ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:
TMWP services are available to Medicaid beneficiaries who receive medical services through Medicaid FFS; are able, or have a caregiver who is able, to respond actively to health information and care coordination activities; and who are identified by HHSC and the TMWP contractor as being high-cost and/or high-risk due to chronic illness or condition. The TMWP contractor receives a per-member-per-month fee for enrollees who opt-in to waiver services, which does not include a component for medical claims. TMWP enrollees receive medical services under the traditional FFS Medicaid program, and not under the waiver itself. At the direction of CMS during the last renewal application, HHSC changed the TMWP delivery system from a Prepaid Ambulatory Health Plan (PAHP) to a PCCM and FFS Selective Contracting system.

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (1 of 3)

1. **Assurances.**

☑ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

☑ The State seeks a waiver of section 1932(a)(3) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

The services provided through the TMWP are a compliment to the services and benefits currently available to Medicaid beneficiaries enrolled in the Medicaid FFS program. Enrollment in the TMWP will not impact enrollees' choice of providers under the Medicaid FFS program. The TMWP is designed to help enrollees

use benefits more effectively through the following: case/care management, a 24/7 Nurse Advice Line, self-management education and the support to develop a medical home. Utilizing a single vendor for the TMWP allows waiver services to be delivered effectively and consistently to enrollees. The State allows disenrollment from the TMWP at the enrollee's discretion.

2. **Details.** The State will provide enrollees with the following choices (please replicate for each program in waiver):

Program: " **Texas Medicaid Wellness Program.** *"*

- ☐ **Two or more MCOs**
- ☐ **Two or more primary care providers within one PCCM system.**
- ☑ **A PCCM or one or more MCOs**
- ☐ **Two or more PIHPs.**
- ☐ **Two or more PAHPs.**
- ☐ **Other:**

please describe

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (2 of 3)

3. **Rural Exception.**

☐ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52 (b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the following areas ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62 (f)(1)(ii)):

4. **1915(b)(4) Selective Contracting.**

◉ **Beneficiaries will be limited to a single provider in their service area**
Please define service area.

TMWP services will be offered by a single PCCM, and do not include medical services. Enrollees receive medical services under the Medicaid FFS Program, and have a choice of medical providers as required by federal law. The TMWP contractor receives a per-member-per-month fee for enrollees who opt-in to waiver services, which does not include a component for medical claims. At the direction of CMS during the last renewal application, HHSC changed the TMWP delivery system from a Prepaid Ambulatory Health Plan (PAHP) to a PCCM and FFS Selective Contracting system.

○ **Beneficiaries will be given a choice of providers in their service area**

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (1 of 2)

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.
   - **Statewide** -- all counties, zip codes, or regions of the State
     -- *Specify Program Instance(s) for Statewide*
     ☑ **TMWP**
   - **Less than Statewide**
     -- *Specify Program Instance(s) for Less than Statewide*
     ☐ **TMWP**
2. **Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Statewide	PCCM	Texas Medicaid Wellness Program

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:
The TMWP provides services as an enhanced benefit to enrollees who are enrolled in the
Medicaid FFS Program and identified as high-cost and/or high-risk. The Medicaid FFS program is statewide.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's specific circumstances.

1. **Included Populations.** The following populations are included in the Waiver Program:

   ☑ **Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.
   - ○ **Mandatory enrollment**
   - ◉ **Voluntary enrollment**

   ☑ **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.
   - ○ **Mandatory enrollment**
   - ◉ **Voluntary enrollment**

   ☑ **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.
   - ○ **Mandatory enrollment**

◉ **Voluntary enrollment**

☑ **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

○ **Mandatory enrollment**
◉ **Voluntary enrollment**

☐ **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

○ **Mandatory enrollment**
○ **Voluntary enrollment**

☐ **Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

○ **Mandatory enrollment**
○ **Voluntary enrollment**

☐ **TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.

○ **Mandatory enrollment**
○ **Voluntary enrollment**

☑ **Other** (Please define):

The following populations are also eligible to participate in the TMWP:
-Fee-for-service dual eligible children under the age of 21
-Children previously in the care of the Department of Family Protective Services (DFPS) who have been adopted or who are in permanent placements, and who now receive Adoption Assistance (AA) or Permanency Care Assistance (PCA) Medicaid

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (2 of 3)

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the program, but "Dual Eligibles" within that population may not be allowed to participate. In addition, "Section 1931 Children" may be able to enroll voluntarily in a managed care program, but "Foster Care Children" within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

☑ **Medicare Dual Eligible** --Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

☐ **Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

☑ **Other Insurance** --Medicaid beneficiaries who have other health insurance.

☑ **Reside in Nursing Facility or ICF/IID** --Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Individuals with Intellectual Disabilities (ICF/IID).

- [x] **Enrolled in Another Managed Care Program** --Medicaid beneficiaries who are enrolled in another Medicaid managed care program
- [ ] **Eligibility Less Than 3 Months** --Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.
- [x] **Participate in HCBS Waiver** --Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).
- [ ] **American Indian/Alaskan Native** --Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.
- [ ] **Special Needs Children (State Defined)** --Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.
- [x] **SCHIP Title XXI Children** – Medicaid beneficiaries who receive services through the SCHIP program.
- [x] **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.
- [x] **Other** (Please define):
  Enrollees in: hospice; the Texas Healthcare Transformation Quality Improvement Program (STAR or STAR+PLUS programs) STAR Health program; as well as undocumented persons;
  Supplemental Security Income (SSI) recipients under 21 years old;
  Fee-for-service individuals under the age of 21 eligible for both Medicare and Medicaid (dual eligible);
  Children and young adults who are eligible for DFPS Foster Care Medicaid and have Medicare due to the existence of a health care condition such as chronic renal disease or maintenance dialysis. As of November 1, 2016, these individuals will receive service management and additional supports, including access to the Health Passport, Through STAR Health.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

F. Services (1 of 5)

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

1. **Assurances.**

   - [ ] The State assures CMS that services under the Waiver Program will comply with the following federal requirements:
     - Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).

- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

☐ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☑ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

☑ The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

Section A: Program Description

Part I: Program Overview

F. Services (2 of 5)

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

   ☑ The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

   Emergency Services Category General Comments (optional):

   The PCCM does not cover emergency services.

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

   ☐ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services.

   ☐ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers.

   ☐ The State will pay for all family planning services, whether provided by network or out-of-network providers.

☐ Other (please explain):

☑ Family planning services are not included under the waiver.

Family Planning Services Category General Comments (optional):

Section A: Program Description

Part I: Program Overview

F. Services (3 of 5)

4. **FQHC Services.** In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

☑ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.

☐ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

☐ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

FQHC Services Category General Comments (optional):

Enrollees in the TMWP do not receive FQHC services through the waiver; however, they are eligible to receive such services through the Medicaid FFS Program.

5. **EPSDT Requirements.**

☐ The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

EPSDT Requirements Category General Comments (optional):

Enrollees in the TMWP do not receive EPSDT services through the waiver; however, they are eligible to receive such services through the Medicaid FFS Program.

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

6. **1915(b)(3) Services.**

☐ This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

1915(b)(3) Services Requirements Category General Comments:

7. **Self-referrals.**

☑ The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

Self-referrals Requirements Category General Comments:

If applicants meet eligibility requirements and want to participate in the TMWP, they may be enrolled through one of the following methods: the PCCM's Navigation Referral, provider or stakeholder referral, or self-referral. Once a referral is received the PCCM will initiate contact.

Clients who call into the Nurse Advice Line (NAL) and are identified as eligible for but not enrolled in the TMWP are also referred to the program. APH operates the NAL. The nurse on the NAL uses a survey known as the Navigation Survey to identify members who may benefit from enrollment in the TMWP. The NAL nurse will provide a transfer to a care management nurse, who can assess and enroll the client into the TMWP.

8. **Other.**

☐ Other (Please describe)

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

1. **Assurances for MCO, PIHP, or PAHP programs**

☐ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

2. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.
   - **a.** ☑ **Availability Standards.** The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.
     1. ☐ PCPs

        Please describe:

     2. ☐ Specialists

        Please describe:

     3. ☐ Ancillary providers

        Please describe:

     4. ☐ Dental

        Please describe:

     5. ☐ Hospitals

        Please describe:

6. ☐ Mental Health

Please describe:

7. ☐ Pharmacies

Please describe:

8. ☐ Substance Abuse Treatment Providers

Please describe:

9. ☑ Other providers

Please describe:

TMWP does not require the enrollee to travel to receive services, as the only service provided is case management. The 24/7 NAL, operated by APH, is available for all eligible TMWP enrollees to call with any immediate symptoms for recommendations or advice. Depending on the care plan, the enrollee may have an option for an in-person case management visit. Case managers travel to the enrollees.

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. Details for PCCM program. (Continued)

b. ☑ **Appointment Scheduling**means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Urgent care

Please describe:

8. ☑ Other providers

Please describe:

Enrollees don't make appointments, but can call a 24/7 Nurse Advice Line for help. The care plan indicates the care management contacts per quarter. Minimum requirements are:
Level 1: 2 successful or 4 consecutive unsuccessful contacts (Levels 1-2 have in-person options)
Level 2: 2 successful or 4 consecutive unsuccessful contacts
Level 3: 1 successful or 4 consecutive unsuccessful contacts

Section A: Program Description

Part II: Access

A. Timely Access Standards (4 of 7)

2. Details for PCCM program. (Continued)

c. ☐ **In-Office Waiting Times**: The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (5 of 7)

2. **Details for PCCM program.** (Continued)

d. ☐ **Other Access Standards**

Section A: Program Description

Part II: Access

A. Timely Access Standards (6 of 7)

3. **Details for 1915(b)(4)FFS selective contracting programs:** Please describe how the State assures timely access to the services covered under the selective contracting program.
A 24/7 Nurse Advice Line (NAL) is available for all eligible TMWP enrollees to call with any immediate symptoms for recommendations/advice. Depending on the care plan, the case manager is required to reach out to the enrollee by telephone or in-person a certain number of times per quarter. The beneficiary's NAL call triggers a reminder to be generated for the primary nurse indicating that the participant has called the NAL. The standard is the primary nurse will call back the next business day to address any remaining needs or gaps in care. For the period of February 2014

through November 2015, the average wait time for the NAL was 19 seconds. APH manages and operates the NAL.

As a point of clarification, the TMWP contractor receives a per-member-per-month fee for enrollees who opt-in to waiver services, which does not include a component for medical claims. TMWP enrollees receive medical services under the traditional FFS Medicaid program, and not under the waiver itself. At the direction of CMS during the last renewal application, HHSC changed the TMWP delivery system from a Prepaid Ambulatory Health Plan (PAHP) to a PCCM and FFS Selective Contracting system.

Section A: Program Description

Part II: Access

A. Timely Access Standards (7 of 7)

Additional Information. Please enter any additional information not included in previous pages:
Additional Information for Section A, Part II, A, 2b-Appointment Scheduling, 8-Other providers:
In-person contacts for all risk levels are optional and can arise for different reasons. Reasons for a home visit can include participant request for any reason, nurse request for issues such as the need to assess the home environment, need to go over education materials in person, or the need to assess a return demonstration. Home visits are also conducted when the contractor is not able to contact a participant telephonically. There is no threshold of non-compliance that would cause a member to be disenrolled. Once a participant has been assessed and enrolled, he or she remains in the program. If the contractor is no longer able to reach the participant telephonically or in the field, the participant is no longer considered an active participant and is coded as "On Demand, Unable to locate." These participants are still outreached quarterly and if the contractor is able to reach them, they once again become active. A participant always has the ability to disenroll at any time. During the initial outreach to Enroll and Assess members, if the contractor has four unsuccessful attempts to reach a participant, the participant is placed in the status "On Demand, Unable to locate." Periodically these participants are attempted again during re-contact efforts.

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

1. **Assurances for MCO, PIHP, or PAHP programs**

☐ The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

Section A: Program Description

Part II: Access

B. Capacity Standards (2 of 6)

2. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.
   - **a.** ☐ The State has set **enrollment limits** for each PCCM primary care provider.

     Please describe the enrollment limits and how each is determined:

   - **b.** ☐ The State ensures that there are adequate number of PCCM PCPs with **open panels**.

     Please describe the State's standard:

   - **c.** ☐ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver.

     Please describe the State's standard for adequate PCP capacity:

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

2. **Details for PCCM program.** (Continued)
   - **d.** ☐ The State compares **numbers of providers** before and during the Waiver.

Provider Type	# Before Waiver	# in Current Waiver	# Expected in Renewal

     Please note any limitations to the data in the chart above:

   - **e.** ☐ The State ensures adequate **geographic distribution** of PCCMs.

     Please describe the State's standard:

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. **Details for PCCM program.** (Continued)
   - **f.** ☐ **PCP:Enrollee Ratio**. The State establishes standards for PCP to enrollee ratios.

Area/(City/County/Region)	PCCM-to-Enrollee Ratio	

Please note any changes that will occur due to the use of physician extenders.:

g. ☑ **Other capacity standards**.

Please describe:

The TMWP PCCM is statewide and not responsible for building a provider network as enrollees access medical services through the FFS Medicaid Program. Per contract, the PCCM may only serve up to 12,000 members per month each quarter. Enrollees have reasonable access to services via a 24/7 NAL. The care plan identifies the number of times per quarter that the care manager must contact the enrollee.

Section A: Program Description

Part II: Access

B. Capacity Standards (5 of 6)

3. **Details for 1915(b)(4)FFS selective contracting programs:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.
The TMWP is administered by one PCCM statewide, and provides only case management services. Enrollees have access to services via a 24/7 Nurse Advice Line, which they may call with symptoms for immediate advice. Depending on the enrollee's care plan, the care manager is required to contact the enrollee by phone or in-person a certain number of times per quarter. The PCCM may only serve up to 6,590 members per month per quarter per contract requirement.

   As a point of clarification, the TMWP contractor receives a per-member-per-month fee for enrollees who opt-in to waiver services, which does not include a component for medical claims. TMWP enrollees receive medical services under the traditional FFS Medicaid program, and not under the waiver itself. At the direction of CMS during the last renewal application, HHSC changed the TMWP delivery system from a Prepaid Ambulatory Health Plan (PAHP) to a PCCM and FFS Selective Contracting system.

Section A: Program Description

Part II: Access

B. Capacity Standards (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:
Additional information for Section A, Part II, B, 2g-Other Capacity Standards:
The contractor currently staffs 19 CBPNs; 1 Behavioral Health Specialist; 2 Complex Care Managers (CCM); 1 pharmacist; 10 CHW/Promotoras; 1 Health Resource Coordinator (HRC) and 2 Social workers. The total number of staff has been adjusted to reflect the reduction in the total amount of eligible members. A staffing model is used to ensure that the contractor has sufficient staff to provide the Disease Management/Chronic Condition Management (DM/CCM) services. This long-term staffing model is updated at least monthly by APH Operations Management for a 3 to 12 month planning horizon. The model uses staffing calculators based on the design of the programs and operational variables, e.g., number of calls by disease and severity, call lengths, reach rates by disease, retention curves, staff efficiencies, regional populations and geographic coverage. The model is updated with information on new or potential clients— to estimate the enrollment and maintenance staffing— for actual enrollment data and current operational performance.

On at least a quarterly basis the caseloads of the DM/CCM personnel are evaluated to ensure that the contractor has sufficient staff assigned to manage the active participants, the staff efficiency is maximized and sufficient cases are being managed in the appropriate diseases to ensure staff members remain competent. If insufficient capacity exists in the caseload staff, enrollment nurses are re-deployed as caseload nurses and the contractor has the option of utilizing the flex staff (nurses

trained on both the Nurse Advice Line and DM/CCM platform) during periods of need. On a monthly basis, the information from the long-term staffing model related to enrollment activity is incorporated into the short-term enrollment work schedule. This tool provides a 13-week planning horizon on the enrollment activities and is used to coordinate the written and telephonic member communications to potential new members. On a weekly basis, the enrollment schedules are firmed up for a four-week planning horizon, balancing the enrollment capacity with the contractual requirements for processing enrollments on a client-by-client basis. For minor forecasted staffing shortages, the recruitment plans will be evaluated, e.g., reviewed to determine whether more frequent recruitment campaigns are required. Significant forecasted staff shortages may be escalated to senior management for alternative action. During periods of excess staffing, recruitment activity may be reduced and voluntary time off offered to staff or can be flexed to DM/CCM if a corresponding need is present.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (1 of 5)

1. Assurances for MCO, PIHP, or PAHP programs

☐ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (2 of 5)

2. Details on MCO/PIHP/PAHP enrollees with special health care needs.

The following items are required.

a. ☐ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208.

Please provide justification for this determination:

b. ☐ **Identification**. The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State.

Please describe:

c. ☐ **Assessment**. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe:

Please describe the enrollment limits and how each is determined:

d. ☐ **Treatment Plans**. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan.If so, the treatment plan meets the following requirements:

1. ☐ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee.
2. ☐ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan).
3. ☐ In accord with any applicable State quality assurance and utilization review standards.

Please describe:

e. ☐ **Direct access to specialists**. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

Please describe:

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (3 of 5)

3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.
   - **a.** ☐ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.
   - **b.** ☐ Each enrollee selects or is assigned to a designated **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.
   - **c.** ☑ Each enrollee is receives **health education/promotion** information.

     Please explain:

     The 24/7 Nurse Advice Line (NAL) is available for all TMWP enrollees to call with any immediate symptoms for recommendations/advice.

     The PCCM will assign each enrollee in the TMWP a primary nurse care manager. This nurse care manager will complete an initial assessment with the enrollee. The assessment process includes the development and implementation of an enrollee plan of care that addresses the beneficiary's multiple physical and behavioral health issues, as well as any barriers to care. The enrollee is given the opportunity to participate in the development of the care plan. Once the care plan is completed the PCCM will forward the completed care plan to the enrollee's primary care provider via e-mail, fax or the web for provider approval or comments.
   - **d.** ☑ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
   - **e.** ☑ There is appropriate and confidential **exchange of information** among providers.

f. ☑ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.

g. ☑ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.

h. ☐ **Additional case management** is provided.

Please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files.

i. ☐ **Referrals.**

Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (4 of 5)

4. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.
As a point of clarification, the TMWP contractor receives a per-member-per-month fee for enrollees who opt-in to waiver services, which does not include a component for medical claims. TMWP enrollees receive medical services under the traditional FFS Medicaid program, and not under the waiver itself. At the direction of CMS during the last renewal application, HHSC changed the TMWP delivery system from a PAHP to a PCCM and FFS Selective Contracting system.

Coordination and continuity of care are not negatively impacted by the selective contracting program, because members are ensured access to the 24/7 Nurse Advice Line (NAL). The NAL is available for all TMWP enrollees to call with any immediate symptoms for recommendations and advice.

HHSC follows the State of Texas procurement standards and processes for the TMWP contract. These are the requirements a potential contractor must meet to be awarded the contract.

A. Ability to achieve HHSC's missions and objectives, including the degree to which the proposal:
• achieves and communicates a clear understanding of HHSC's missions and objectives;
• includes a well-reasoned approach to fulfilling the program's requirements; and meets the needs of HHSC, and TMWP clients and providers.
B. The degree to which the proposal demonstrates program innovation, adaptability and exceptional customer service.
C. The respondent's demonstrated competence and qualifications, including:
• knowledge of health management through experience with Medicaid and/or vulnerable populations;
• knowledge of the Texas health care environment, including Medicaid providers and clients;
• expertise in medical practice facilitation;
• skills and abilities of key personnel related to the goals of the TMWP;
• reporting, evaluation design, and expertise; and
• respondent's organizational capacity.
D. The total program cost, including:
• the respondent's ability to fulfill all contract requirements at an acceptable cost; and respondent's ability to produce cost savings for the State of Texas.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:
While the PCCM helps facilitate access to specialty care, it is not responsible for service authorization. Enrollees have access to specialists through the Medicaid FFS Program.

Section A: Program Description

Part III: Quality

1. **Assurances for MCO or PIHP programs**

☐ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.
The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on: *(mm/dd/yy)*

☐ The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004.
Please provide the information below (modify chart as necessary):

Program Type	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO				
PIHP				

Section A: Program Description

Part III: Quality

2. **Assurances For PAHP program**

☐ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.
   - **a.** ☑ The State has developed a set of overall quality **improvement guidelines** for its PCCM program.

     Please describe:

     This waiver only provides case management services and does not offer medical services. The enrollees have access to medically necessary services under the Medicaid FFS program.
     In order to assure quality of care in the case management service provided by the program, twenty percent of the fees paid to the PCCM for the TMWP are recouped based on the PCCM's ability to achieve targeted savings and performance measures. In order to receive the full PMPM fee for clients enrolled in the TMWP, the PCCM must achieve the following performance results:
     •Cost savings: Each program period, the PCCM must reduce total medical expenditures for clients enrolled in the TMWP by a minimum of 3.6 percent of the total annual claims cost for that population.
     •Quality Indicators: The PCCM must incorporate the core clinical quality indicators identified by HHSC through a comparative analysis of Texas Medicaid programs. Other indicators will be agreed upon by HHSC and the PCCM.
     •Humanistic outcomes: The PCCM must conduct annual surveys using HHSC approved client, official caregiver, and provider satisfaction survey tools.

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** (Continued)
   - **b.** ☑ **State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below.
     1. ☑ Provide education and informal mailings to beneficiaries and PCCMs
     2. ☑ Initiate telephone and/or mail inquiries and follow-up
     3. ☑ Request PCCM's response to identified problems
     4. ☑ Refer to program staff for further investigation
     5. ☑ Send warning letters to PCCMs
     6. ☑ Refer to State's medical staff for investigation
     7. ☑ Institute corrective action plans and follow-up

8. ☐ Change an enrollee's PCCM
9. ☐ Institute a restriction on the types of enrollees
10. ☐ Further limit the number of assignments
11. ☐ Ban new assignments
12. ☐ Transfer some or all assignments to different PCCMs
13. ☑ Suspend or terminate PCCM agreement
14. ☐ Suspend or terminate as Medicaid providers
15. ☑ Other

Please explain:

The State would not inform the beneficiaries because the contractor is the entity responsible for communicating with beneficiaries.

The State communicates all problems identified regarding the quality of services to the contractor via e-mail and/or in person during regular weekly and monthly operations calls/meetings.

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** (Continued)
   - c. ☑ **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.
     Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):
     1. ☑ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
     2. ☐ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
     3. ☑ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
        - **A.** ☐ Initial credentialing
        - **B.** ☑ Performance measures, including those obtained through the following (check all that apply):
          - ☐ The utilization management system.
          - ☐ The complaint and appeals system.
          - ☐ Enrollee surveys.
          - ☑ Other.

Please describe:

HHSC verifies that qualified personnel have necessary licenses and certifications as required by the contract when interviewing staff during the yearly on-site-review. HHSC does not interview all licensed and certified staff members during the onsite review. HHSC staff interviews a selected number of staff and verifies that the license or certification is current. APH provides HHSC staff with a current list of all staff members with current license and certification information at the time of the onsite review. Criminal background and registry checks are also provided upon request during the onsite review.

4. ☐ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
5. ☐ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
6. ☐ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
7. ☑ Other

Please explain:

The TMWP contractor is not licensed, certified, or registered as a PCCM under state law. The TMWP is operated as a combination PCCM and FFS Selective Contracting system in accordance with CMS direction, although the TMWP does not provide medical care and reimburses the contractor on a per member per month basis.

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** (Continued)

d. Other quality standards (please describe):
This waiver ensures beneficiaries have access to medically necessary services under the Medicaid FFS program. TMWP relies on the Accenture provider-enrollment screening processes to determine provider quality.
In addition, HHSC verifies that qualified personnel have necessary licenses and certifications as required by the contract when interviewing staff during the yearly on-site-review.

Section A: Program Description

Part III: Quality

4. **Details for 1915(b)(4) only programs:** Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:
As a point of clarification, the TMWP contractor receives a per-member-per-month fee for enrollees who opt-in to waiver services, which does not include a component for medical claims. TMWP enrollees receive medical services under the traditional FFS Medicaid program, and not under the waiver itself. At the direction of CMS during the last renewal application, HHSC changed the TMWP delivery system from a Prepaid Ambulatory Health Plan (PAHP) to a PCCM and FFS Selective Contracting system.

The State selected the PCCM through a competitive procurement process. The evaluation criteria included the following factors, listed in order of priority:
A. Ability to achieve HHSC's missions and objectives, including the degree to which the proposal:
•achieves and communicates a clear understanding of HHSC's missions and objectives;
•includes a well-reasoned approach to fulfilling the program's requirements; and meets the needs of HHSC, and the TMWP clients and providers.
B. The degree to which the proposal demonstrates program innovation, adaptability and exceptional customer service.
C. The respondent's demonstrated competence and qualifications, including:
•knowledge of health management through experience with Medicaid and/or vulnerable populations;
•knowledge of the Texas health care environment, including Medicaid providers and clients;
•expertise in medical practice facilitation;
•skills and abilities of key personnel related to the goals of the TMWP;
•reporting, evaluation design, and expertise; and
•the PCCM's organizational capacity.

D. The total program cost, including:
• the PCCM's ability to fulfill all contract requirements at an acceptable cost; and the PCCM's ability to produce cost savings for the State of Texas.

Section A: Program Description

Part IV: Program Operations

A. Marketing (1 of 4)

1. Assurances

- [x] The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.
- [ ] The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

  Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- [x] The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- [x] This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

A. Marketing (2 of 4)

2. Details

a. Scope of Marketing

1. [ ] The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.
2. [ ] The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general).

   Please list types of indirect marketing permitted:

3. [x] The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries).

   Please list types of direct marketing permitted:

   Enrollees receive enrollment materials, interactive voice recording for reminders and program notices, as well as ongoing educational materials to support self-management and their plans of care. A website also disseminates program information. Once contacted, a member may choose to enroll in the TMWP or not be contacted again.

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. **Details** (Continued)

b. Description. Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1. ☐ The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees.

Please explain any limitation or prohibition and how the State monitors this:

2. ☐ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan.

Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3. ☑ The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials.

Please list languages materials will be translated into. (If the State does not translate or require the translation of marketing materials, please explain):

The PCCM must translate all program materials into the languages of groups comprising 10 percent (10%) or more of the enrolled population. At the time of waiver submission, Spanish is the only language that meets this criterion. Program materials can be translated into other languages upon request.

The State has chosen these languages because (check any that apply):

a. ☐ The languages comprise all prevalent languages in the service area.

Please describe the methodology for determining prevalent languages:

b.

☑ The languages comprise all languages in the service area spoken by approximately 10 percent or more of the population.

c. ☐ Other

Please explain:

Section A: Program Description

Part IV: Program Operations

A. Marketing (4 of 4)

Additional Information. Please enter any additional information not included in previous pages:
As a point of clarification, the TMWP contractor receives a per-member-per-month fee for enrollees who opt-in to waiver services, which does not include a component for medical claims. TMWP enrollees receive medical services under the traditional FFS Medicaid program, and not under the waiver itself. At the direction of CMS during the last renewal application, HHSC changed the TMWP delivery system from a Prepaid Ambulatory Health Plan (PAHP) to a PCCM and FFS Selective Contracting system.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (1 of 5)

1. Assurances

- [x] The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.
- [ ] The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

  Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:
- [ ] The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- [x] This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (2 of 5)

2. Details

a. Non-English Languages

1. [x] Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

Please list languages materials will be translated into. (If the State does not require written materials to be translated, please explain):

The PCCM must translate all program materials into the languages of groups comprising 10 percent or more of the enrolled population. At the time of waiver submission, Spanish is the only language that meets this criterion.

If the State does not translate or require the translation of marketing materials, please explain:

The State defines prevalent non-English languages as: (check any that apply):

a. ☐ The languages spoken by significant number of potential enrollees and enrollees.

Please explain how the State defines "significant.":

b. ☑ The languages spoken by approximately 10.00 percent or more of the potential enrollee/enrollee population.

c. ☐ Other

Please explain:

2. ☑ Please describe how oral translation services are available to all potential enrollees and enrollees, regardless of language spoken.

If an enrollee speaks a language other than English or Spanish, enrollees will be offered services through a translation service sub-contractor.

3. ☑ The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program.

Please describe:

The PCCM is responsible for helping enrollees and potential enrollees understand the managed care program. The PCCM must translate all program materials into the languages of groups, comprising 10 percent (10%) or more of the enrolled population. The State monitors the PCCM at least annually to ensure compliance.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (3 of 5)

2. Details (Continued)

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

☐ State

☑ Contractor

Please specify:

The PCCM will distribute information to potential enrollees through the following communication methods, at a minimum: interactive voice response, mail, telephone, or face-to-face visits.

☐ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP.)

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (4 of 5)

2. **Details** (Continued)

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

- ☐ the State
- ☑ State contractor

Please specify:

The 'State contractor' and the PCCM provider is the same entity. APH provides required information to the enrollees by training and educating the individual either face-to-face or telephonically. They also provide educational materials via regular mail.

- ☑ The MCO/PIHP/PAHP/PCCM/FFS selective contracting provider.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:
The PCCM will distribute information to enrollees via the following communication methods, at a minimum: interactive voice response, mail, telephone, or face-to-face visits.

As a point of clarification, the TMWP contractor receives a per-member-per-month fee for enrollees who opt-in to waiver services, which does not include a component for medical claims. TMWP enrollees receive medical services under the traditional FFS Medicaid program, and not under the waiver itself. At the direction of CMS during the last renewal application, HHSC changed the TMWP delivery system from a Prepaid Ambulatory Health Plan (PAHP) to a PCCM and FFS Selective Contracting system.

Additional Information for Section A, Part IV, B, 2a- Non English Languages, 1:
Translation services are provided at no cost to the member. Should a client need help understanding one of the print pieces, he or she can request a care manager to coordinate translation over the phone.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (1 of 6)

1. **Assurances**

- ☑ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.
- ☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C.)

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- ☑ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions

will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☑ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (2 of 6)

2. Details

Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. Outreach

☑ The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program.

Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

The PCCM contacts potential enrollees through the following communication methods, at a minimum: mail, telephone, interactive voice response, or face-to-face visits. In cases where enrollees are unable to be located by mail or telephone, in-person efforts are made to contact the enrollees. PCCM staff are community-based and expected to build relationships with various local entities to better enable successful potential enrollee communication. If an enrollee requests information about the State's Medicaid managed care program the enrollee is either provided with that information or referred to the TMHP Medicaid Helpline.

The PCCM will invite the enrollee's identified PCP participation by mail, telephone or in-person office visits.

The PCCM uses culturally sensitive approaches specifically tailored for rural and urban areas to outreach, locate, and enroll hard-to-reach Medicaid clients.

The State's outreach efforts, through the PCCM, do not violate privacy or confidentiality when an individual applies for assistance with HHSC they receive and sign the document "Your Texas Benefits," which states on page 18, Section M, Statement of Understanding:
"HHSC can share facts about me when needed for me to get state health care benefits." The option to enroll in the TMWP is part of the state health care benefits.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (3 of 6)

2. Details (Continued)

b. Administration of Enrollment Process

☐ State staff conducts the enrollment process.

☐ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

☐ The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name:

Please list the functions that the contractor will perform:

- ☐ choice counseling
- ☐ enrollment
- ☐ other

Please describe:

☑ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries.

Please describe the process:

HHSC provides the PCCM with a monthly data file of medical and pharmacy claims to identify potential enrollees. The PCCM will use State-approved predictive modeling software to identify then stratify potential enrollees based on risk and potential to benefit from the waiver. When the PCCM reaches an enrollee, it will administer a health risk assessment. These data are used in conjunction with predictive modeling results to develop a care plan and identify the appropriate intervention level.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (4 of 6)

2. Details (Continued)

c. Enrollment . The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

☐ This is a **new** program.

Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

☑ This is an **existing program** that will be expanded during the renewal period.

Please describe: Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

As Medicaid members become ineligible for the TMWP on a monthly basis, new members are identified as eligible for the program. As Medicaid members become ineligible for the TMWP on a monthly basis, new members are identified as eligible for the program. The PCCM will reach out to the high cost/high risk eligible members once they are loaded to the PCCMs system. Under its contract with HHSC, the PCCM maintains an average of 12,000 active members per quarter.

Additional enrollees identified monthly through the State-approved predictive modeling approach will begin receiving services upon completion of the health risk assessment and care plan.

☐ If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

i.

☐ Potential enrollees will have ○ **day(s)** / ○ **month(s)** to choose a plan.

ii. ☐ There is an auto-assignment process or algorithm.

In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs:

☐ The State automatically enrolls beneficiaries.

- ☐ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3).
- ☐ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1).
- ☐ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause.

Please specify geographic areas where this occurs:

☐ The State provides **guaranteed eligibility** of ____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

☐ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM.

Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

☑ The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (5 of 6)

2. Details (Continued)

d. Disenrollment

☑ The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

- **i.** ☐ Enrollee submits request to State.
- **ii.** ☑ Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.
- **iii.** ☐ Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

☐ The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

☐ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of [ ] months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

☑ The State does not have a **lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

☑ The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees.

i. ☐ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee.

Please describe the reasons for which enrollees can request reassignment

ii. ☑ The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.

iii. ☐ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.

iv. ☐ The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:
Enrollees may request disenrollment at any time by notifying the PCCM in writing, via phone or by fax.

The PCCM may request disenrollment of a member from the program for disruptive behavior that seriously impairs the PCCMs ability to provide services. The PCCM cannot request a disenrollment based on adverse change in the member's health status or utilization of services, which are medically necessary for the treatment of a member's condition. In addition, the PCCM may not request a disenrollment of an individual based on the grounds of race, color, national origin, sex, age, disability, political beliefs or religion. All disenrollment requests must be reviewed and approved by HHSC.

As a point of clarification, the TMWP contractor receives a per-member-per-month fee for enrollees who opt-in to waiver services, which does not include a component for medical claims. TMWP enrollees receive medical services under the traditional FFS Medicaid program, and not under the waiver itself. At the direction of CMS during the last renewal application, HHSC changed the TMWP delivery system from a Prepaid Ambulatory Health Plan (PAHP) to a PCCM and FFS Selective Contracting system.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

1. **Assurances**

- [x] The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.
- [ ] The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

  Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- [x] The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- [x] This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.
- [x] The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:
As a point of clarification, the TMWP contractor receives a per-member-per-month fee for enrollees who opt-in to waiver services, which does not include a component for medical claims. TMWP enrollees receive medical services under the traditional FFS Medicaid program, and not under the waiver itself. At the direction of CMS during the last renewal application, HHSC changed the TMWP delivery system from a Prepaid Ambulatory Health Plan (PAHP) to a PCCM and FFS Selective Contracting system.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (1 of 5)

1. **Assurances for All Programs** States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

   a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
   b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
   c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

   - [x] The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (2 of 5)

2. **Assurances For MCO or PIHP programs**. MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

   ☐ The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

   Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

   ☐ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (3 of 5)

3. **Details for MCO or PIHP programs**

   a. **Direct Access to Fair Hearing**

   ☐ The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.
   ☐ The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

   b. **Timeframes**

   ☐ The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is ____ days (between 20 and 90).
   ☐ The State's timeframe within which an enrollee must file a **grievance** is ____ days.

   c. **Special Needs**

   ☐ The State has special processes in place for persons with special needs.

   Please describe:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (4 of 5)

4. **Optional grievance systems for PCCM and PAHP programs**. States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

☑ The State has a grievance procedure for its ☑ PCCM and/or ☐ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

The grievance procedures are operated by:

- ☑ the State
- ☐ the State's contractor.

  Please identify:
- ☐ the PCCM
- ☐ the PAHP

☑ Requests for review can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals):

Please describe:

PCCM staff review and resolve complaints. If the enrollee or provider is unsatisfied with the PCCM's resolution, a HHSC review can be requested. The HHSC Ombudsman Office conducts the review and initially has five days to resolve the issue or refer to a fair hearing. The complaint must be resolved within 90 days of the date of the adverse action.

☑ Has a committee or staff who review and resolve requests for review.

Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function:

The PCCM has an internal process to review and resolve complaints. If, after the complaint is resolved, the enrollee or provider is not satisfied with the resolution of a complaint, they can request a HHSC fair hearing.

☐ Specifies a time frame from the date of action for the enrollee to file a request for review.

Please specify the time frame for each type of request for review:

☑ Has time frames for resolving requests for review.

Specify the time period set for each type of request for review:

The PCCM must resolve the complaint within 30 calendar days of receiving the complaint, regardless of the type of complaint.

☐ Establishes and maintains an expedited review process.

Please explain the reasons for the process and specify the time frame set by the State for this process:

☐ Permits enrollees to appear before State PCCM/PAHP personnel responsible for resolving the request for review.

☑ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

☐ Other.

Please explain:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:
The TMWP PCCM informs the individual of their rights in a resolution letter which is sent to the individual after a complaint is filed in cases where further action is available or necessary.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. Assurances

☑ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

1. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
2. A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;
3. A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

☑ The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

1. Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2. Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3. Employs or contracts directly or indirectly with an individual or entity that is
   a. Excluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
   b. Could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

☐ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

☐ State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under "Evaluation of Program Impact."
  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Program Impact

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ FFS	☐ FFS	☐ FFS	☐ FFS	☐ FFS	☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO	☐ MCO	☐ MCO	☐ MCO	☐ MCO	☐ MCO

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Other	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☑ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under "Evaluation of Program Impact."
  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Access

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☑ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO	☐ MCO	☐ MCO

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Other	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under "Evaluation of Program Impact."
  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Quality

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ PAHP ☑ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☑ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS
Other	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☑ PCCM ☐ FFS

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

For each program authorized by this waiver, please provide the details of its monitoring activities by editing each program listed below.

Programs Authorized by this Waiver:

Program	Type of Program
TMWP	PCCM;

Note: If no programs appear in this list, please define the programs authorized by this waiver on the

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: Texas Medicaid Wellness Program

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.
For each activity, the state must provide the following information:

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a.

☐ **Accreditation for Non-duplication** (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

Activity Details:

☐ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

b. ☐ **Accreditation for Participation** (i.e. as prerequisite to be Medicaid plan)

Activity Details:

☐ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

c. ☑ **Consumer Self-Report data**

Activity Details:

Applicable Program: PCCM Personnel Responsible: PCCM
Description: Consumer self-report data are received through multiple channels including an annual quality of life survey, complaints and ongoing personal interaction with PCCM staff.

Frequency:
• Quality of Life and Functional Status survey administered annually.
• Complaints are addressed as needed per State timeframes.
How it yields information: The data received provide information about the quality of life of enrollees in the TMWP. The survey and outcomes are compared to benchmark scores that assess program effectiveness for maintaining or improving their quality of life.

☑ **CAHPS**

Please identify which one(s):
The PCCM will administer up to three standard surveys, which are linked to fees subject to recoupment: (1) SF-12 Functional Status Survey for adults, (2) SF-10 Functional Status Survey for children if a large proportion of children are served by the waiver, and (3) the Care Continuum Alliance (CCA) Participant Satisfaction survey.

☐ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☑ **Data Analysis (non-claims)**

Activity Details:

Applicable Program: PCCM Personnel Responsible: PCCM
Description: The PCCM will provide weekly reports to the State on disenrollment requests and grievances.
Frequency: Weekly, HHSC continues to monitor activities regarding the disenrollment

process.
How it yields information: These reports allow HHSC to track trends in disenrollments and grievances and assess the need for any program improvements.

- [ ] **Denials of referral requests**
- [x] **Disenrollment requests by enrollee**
  - [x] **From plan**
  - [ ] **From PCP within plan**
- [x] **Grievances and appeals data**
- [ ] **Other**

Please describe:

e. [x] **Enrollee Hotlines**

Activity Details:
Applicable Program: PCCM Personnel Responsible: PCCM
Description: The PCCM must provide a toll-free nurse consultation service that is available 24 hours per day, seven (7) days per week. The consultation line will be staffed by registered nurses who will respond to questions by enrollees and/or their caregivers. The consultation line staff will provide access to translation services and Medicaid resources. The 24 hour NAL is available to all TMWP-eligible individuals.

Frequency: Monthly, quarterly, and annual reporting.

How it yields information: Reports from the consultation lines will provide HHSC information on the number of calls, types of callers, and the types of inquiries enrollees request.

f. [ ] **Focused Studies** (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service)

Activity Details:

g. [x] **Geographic mapping**

Activity Details:
Applicable Program: PCCM Personnel Responsible: PCCM
Description: The PCCM will use a State map with program population density overlaid with staffing and caseload expectations. Several changes to the program staffing of Regional Care Teams were made during Program Period 1 to respond to the changes in population density in certain areas of the state

Frequency: Ongoing. HHSC continues to monitor activities regarding population density to ensure all regions are properly staffed.
How it yields information: The PCCM will utilize enrollee population mapping to ensure adequate regional primary nurse care manager coverage as program population evolves over time.

h. [x] **Independent Assessment** (Required for first two waiver periods)

Activity Details:
Applicable Program: PCCM Personnel Responsible: PCCM
Description: The State will arrange for an independently contracted evaluator to assess continuity of care, trends in medical utilization and costs, qualitative measures and the results of satisfaction reports from enrollees and providers.

Frequency: Biennial

How it yields information: Biennial program assessments will provide data regarding actual trends in planned outcomes for the program and provide input for more effective health management services.

i. ☑ **Measure any Disparities by Racial or Ethnic Groups**

Activity Details:
Applicable Program: PCCM Personnel Responsible: PCCM
Description: The PCCM must develop comprehensive and culturally sensitive methods of outreach and outcomes measures for enrollees, racial groups and ethnic groups with identified healthcare disparities. The PCCM will provide HHSC with monthly reports of results related to these populations. In addition, enrollee satisfaction surveys will include questions on access and quality of services provided to all enrollees identified for program inclusion.

Frequency: Monthly

How it yields information: Annual evaluations will be available to the PCCM and HHSC regarding service access and provision of services to all program enrollees, including populations with healthcare disparities. The data will provide feedback to the PCCM and HHSC on ways to refine culturally sensitive methods of health management service delivery.

j. ☐ **Network Adequacy Assurance by Plan** [Required for MCO/PIHP/PAHP]

Activity Details:

k. ☐ **Ombudsman**

Activity Details:

l. ☑ **On-Site Review**

Activity Details:
Applicable Program: PCCM
Personnel Responsible: HHSC
Description: HHSC conducted an initial onsite visit to determine operational readiness and conducts annual onsite evaluation reviews.
Frequency: Initial (one time), HHSC continues to monitor PCCM through annual on-site evaluations.
How it yields information: Onsite reviews demonstrate the PCCM's operational capacity and verify whether the PCCM is in compliance with the contract requirements.

m. ☐ **Performance Improvement Projects** [Required for MCO/PIHP]

Activity Details:

☐ **Clinical**

☐ **Non-clinical**

n. ☑ **Performance Measures** [Required for MCO/PIHP]

Activity Details:
Applicable Program: PCCM
Personnel Responsible: PCCM and HHSC
Description: The TMWP will use claims, self-reported clinical performance indicators, deliverables and performance standards to gauge program effectiveness. In cases where standards are not met, HHSC will require corrective action measures and may assess

financial damages. HHSC and PCCM monitoring activities include oversight of quality processes, service delivery and evidence-based guidelines. HHSC used a performance-based Request For Proposal (RFP) and contract for TMWP services. This includes performance indicators, deliverables, performance standards and specific liquidated damages with plans of correction for failure to meet performance standards. Frequency: Ongoing. HHSC monitors all performance indicators, deliverables and performance standards on a monthly, quarterly and annual basis.

How it yields information: Performance measures of quality processes, service delivery, and intervention methods will be evaluated in conjunction with cost and efficiency measures. The combined data will be reviewed annually for validation of program outcomes and to refine performance measures for the next year.

- ☐ **Process**
- ☐ **Health status/ outcomes**
- ☐ **Access/ availability of care**
- ☐ **Use of services/ utilization**
- ☐ **Health plan stability/ financial/ cost of care**
- ☐ **Health plan/ provider characteristics**
- ☐ **Beneficiary characteristics**

o. ☐ **Periodic Comparison of # of Providers**

Activity Details:

p. ☐ **Profile Utilization by Provider Caseload** (looking for outliers)

Activity Details:

q. ☑ **Provider Self-Report Data**

Activity Details:

Applicable Program: PCCM Personnel Responsible: PCCM
Description: The PCCM must develop a comprehensive provider satisfaction survey that must be approved by HHSC. The results of the provider survey will be aggregated annually and reported to HHSC for review. Frequency: Annual
How it yields information: The reports are used to assess the level of provider engagement in the health management process and overall satisfaction with the TMWP.

- ☑ **Survey of providers**
- ☐ **Focus groups**

r. ☐ **Test 24/7 PCP Availability**

Activity Details:

s. ☑ **Utilization Review** (e.g. ER, non-authorized specialist requests)

Activity Details:

Applicable Program: PCCM Personnel Responsible: PCCM
Description: The PCCM measures utilization and medical costs annually through an agreed-upon reconciliation process with HHSC. Examples of utilization measures include hospital admissions and emergency room visits by enrollees enrolled in TMWP.
Frequency: Annually
How it yields information: The reports are used to assess impact and overall effectiveness of the TMWP.

t. ☑ **Other**

Activity Details:

Applicable Program: PCCM
Personnel Responsible: PCCM and HHSC
Description: The PCCM must ensure that the member is given a choice to opt-in to the TMWP or opt-out of the program. The PCCM completes a health assessment when the member chooses to enroll in the program. When the member chooses to not enroll the PCCM makes a note in the member's record. Frequency: Ongoing
How it yields information: Ongoing monitoring/review will demonstrate that members have a choice to join or decline the TMWP case management services.

Applicable Program: PCCM
Personnel Responsible: HHSC and PCCM
Description: The State regularly monitors contractor performance at the quarterly quality committee meetings and during the annual onsite review. The results of the independent assessment are included in the review tool used by state staff for the annual on-site review. If a corrective action plan is needed as a result of the independent assessment, the elements of the corrective action plan will also be part of the review tool. State staff will review the Independent Assessment and the corrective action plan prior to the on-site review to ensure that all noted deficiencies in the Independent Assessment and from the corrective action plan have been added to the review tool and are addressed at the time of the on-site review. Review of the Independent Assessment report by state and contractor staff will be on-going until all deficiencies are corrected. State staff will add the results of the Independent Assessment, including the elements of the corrective action plan, to the TMWP Quality Improvement Program Plan, which will be reviewed on a quarterly basis to ensure that the contractor is in compliance with program processes and has implemented the correction plan as stated. The State will also select a sample of clients on a quarterly basis and review all records maintained by the contractor to ensure that all staff are documenting appropriately. The State will provide results to the contractor upon completion of the review.
Frequency: Quarterly and Annually. On-going training and mentoring of staff.
How it yields information: The monitoring ensures that contractor is in compliance with program process and is correcting any deficiencies identified in the Independent Assessment and listed in the corrective action plan.

Applicable Program: PCCM
Personnel Responsible: HHSC and PCCM
Description: The State will monitor APH's client targeting and recruitment process on a monthly and quarterly basis. If there is a delay for any reason, the contractor will notify the State in writing (via email) of the delay and the reason for the delay. The contractor also will provide a new timeline and request an extension to the due date. The State will respond to the contractor in writing (via email) whether the State will accept or deny the request for the extension. These monitoring processes are part of the review tool used by state staff for the annual on-site review. Staff will continue to use the review tool and will meet with APH management staff and review all documentation during the on-site review. State staff will ensure that the processes are also added to the TMWP Quality Improvement Program Plan and will be reviewed on a quarterly basis to ensure that the contractor is completing the process on a timely manner.
Frequency: Monthly, Quarterly and Annually
How it yields information: The monitoring ensures that the contractor is targeting and recruiting clients in a timely manner.

Applicable Program: PCCM
Personnel Responsible: HHSC and PCCM
Description: The State receives CHW/Promotora monitoring reports from APH each quarter providing information about call monitoring, live monitoring, monitoring productivity statistics, field productivity statistics, field activity log audits, chart audits, supervising coaching, and supervisor meeting. These monitoring reports are part of the review tool used by state staff for the annual on-site review. Staff will continue to use the

review tool and will meet with APH management staff and review all documentation during the on-site review. State staff will ensure that the elements of the reports are also added to the TMWP Quality Improvement Program Plan and will be reviewed on a quarterly basis to ensure that the CHW/Promotora roles and responsibilities are occurring as a standard practice.
Frequency: Monthly, Quarterly and Annually
How it yields information: The monitoring ensures that the CHW/Promotora roles and responsibilities are occurring as a standard practice.

Section C: Monitoring Results

Renewal Waiver Request

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

This is a renewal request.

- ○ **This is the first time the State is using this waiver format to renew an existing waiver.** The State provides below the results of the monitoring activities conducted during the previous waiver period.
- ◉ **The State has used this format previously** The State provides below the results of the monitoring activities conducted during the previous waiver period.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

The Monitoring Activities were conducted as described:

◉ **Yes** ○ **No**

If No, please explain:

Provide the results of the monitoring activities:

Strategy: Consumer Self-Report Data
Results: A total of 3,842 clients completed the survey, of whom a majority (90% to 96%)rated their overall experience as "6, 7, 8, 9 or 10" about the overall program, coordination of care, health improvements resulting from program participation, and staying involved in their own health care management because of program participation. Also, 97.9% of clients completing the survey reported that the TMWP has encouraged them to make at least one lifestyle change to better manage their condition. Problems identified: None. Program Change: None.Strategy: Data Analysis
Results: The PCCM tracks acceptance, refusal to participate, disenrollment of enrolled participants, and the reason for refusal/disenrollment. HHSC monitors this report to assess any trends. For grievances, the State is notified each time an

enrollee or provider issues a complaint against the PCCM, the State or a provider. Each complaint is reviewed by the PCCM and HHSC. Response to the complaint is prompt and courteous. Although the TMWP has never had an appeal, the grievances and appeals process for the PCCM operates independently and in addition to the Medicaid Fair Hearings process. Problems identified: None. Program Change: None

Strategy: Enrollee Hotlines Operated by the State
Results: Reports about total call volume are provided to the State by the PCCM. The care management staff processed 3,906 inbound RN encounters & 35% of these were symptomatic, meaning that the RN gave a recommendation for a medical issue. Reducing
inappropriate use of the ED is a program goal. Of clients who said they would have gone to the
ED if they had not called, 88% were directed to seek a lower level of care. Problems identified: None. Program Change: None

Strategy: Geographic mapping
Results: Geographic population density maps, are discussed quarterly between HHSC and the PCCM. Problems identified: None. Program Change: None

Strategy: Independent Assessment (IA)
Results: The IA was done in July 2015 and submitted with the renewal. Problems identified: Clinical notes provided a limited picture of the member, the interventions provided, and incorrect coding of the type of contact. Corrective action: The contractor provided refresher training to all staff. HHSC added the IA results to the quarterly Quality Management Committee meeting (QMC) agenda, developed a project plan and added it to the annual onsite review to ensure all items are tracked and monitored. Program change: None.

Strategy: Measurement of any disparities by racial or ethnic groups
Results: Records and reports, as developed by the PCCM, indicate that within this program, there are no measurable disparities by racial or ethnic groups. Problems identified: None. Program Change: None

Strategy: On-site Review 2016-PP5
Results: An annual on-site review of the PCCM was conducted by HHSC. During the annual evaluation for the fifth program period (PP), most elements of the review were met or exceeded. It was recommended that the PCCM continue operations. Problems identified: Documentation in the clinical files
does not provide sufficient information of the member, interventions provided. Also noted was the incorrect coding of the type of contact made. It was identified that this is a system issue. APH is working to correct this issue. Corrective action: Contractor has submitted a plan of correction to HHSC. HHSC conducts reviews of PCCM clinical records on a monthly basis to ensure notes have detailed and concise information on the member. Program change: APH worked with HHSC and the TMWP QMC to evaluate the internal auditing tool, to include assessment of the quality of documentation and level of detail, and to build consistency among PCCM staff.

Strategy: Performance Measures
Results The content of monitoring activities by the State and PCCM include oversight of quality processes, service delivery and disease-specific performance measures. Problems identified: None. Program Change: None

Strategy: Provider self-report data
Results: Results and outcomes for the fifth PP were completed in March 2016. Among those providers who are familiar with the features and goals of the TMWP, most respondents felt that the program is beneficial to both patients and providers. A considerable number of survey respondents that recommended the program to eligible patients believe the program helps patients take better care of themselves. Most respondents felt that the program is useful to both providers and patients in that it helps keep them up-to-date on guidelines for chronic condition management. Problems identified: None. Program change: None.

Strategy: Utilization review
Results: PCCM utilization results for the fifth PP will be completed by the end of November 2016. Problems identified: None
Program Change: None

Strategy: choice opt-in or opt-out of the TMWP
Results: monthly reports show the number of members who were actively managed for the month and also the number of members who declined participation in the program.
Problems identified: None
Program change: None

Strategy: Contractor performance
Results: a project plan was developed to address all deficiencies noted in the IA. PCCM and HHSC meet weekly to review plan.
Problems Identified: Member records are still not clear and concise. APH management is working with supervisors to ensure that all staff have proper training and support.
Program Change: None

Strategy: Client targeting and recruitment process
Results: Records and reports developed by the PCCM indicate that client targeting and recruitment are occurring on a timely basis.
Problems Identified: None Program Change: None

Strategy: CHW/Promotora monitoring reports
Results: Records and reports, as developed by the PCCM, indicate that within this program the CHW/Promotora roles and responsibilities are occurring as a standard practice.
Problems Identified: None Program Change: None

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
Texas Medicaid Wellness Program	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	04/01/2013	03/31/2014	04/01/2014	03/31/2015
Enrollment Projections for the Time Period*	01/01/2016	12/31/2016	01/01/2017	12/31/2017
**Include actual data and dates used in conversion - no estimates *Projections start on Quarter and include data for requested waiver period				

Section D: Cost-Effectiveness

Services Included in the Waiver

Document the services included in the waiver cost-effectiveness analysis:

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Lab or Radiology (Includes Psych)	☑	☐	☐	
SSI Dual Eligible under 21	☑	☐	☐	
Rural Health Clinic	☑	☐	☐	
	☐	☐	☐	
Prescribed Drugs	☑	☐	☐	
Other Practitioners (Includes Psych)	☑	☐	☐	
dental services	☑	☐	☐	
Fees to Contractor for Texas Medicaid Health Management Services	☐	☐	☑	
Tribal 638	☑	☐	☐	
Family Planning				

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
	☑	☐	☐	
Mental Health Facility	☑	☐	☐	
Physician Services (includes Psych)	☑	☐	☐	
IHS Inpatient	☑	☐	☐	
Sterilizations	☑	☐	☐	
Skilled Nursing Home	☑	☐	☐	
ICF-MR Public	☑	☐	☐	
FQHC	☑	☐	☐	
Other Care Services	☑	☐	☐	
IHS Outpatient	☑	☐	☐	
Home Health Services	☑	☐	☐	
ICF-MR Private	☑	☐	☐	
Clinic Services	☑	☐	☐	
EPSDT Screening	☑	☐	☐	
ICF-Other	☑	☐	☐	
Inpatient Hospital (includes Psych)	☑	☐	☐	
Outpatient Hospital (Includes Psych)	☑	☐	☐	

Section D: Cost-Effectiveness

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

Signature: Sallie Allen

State Medicaid Director or Designee

Submission Date: Jan 6, 2017

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

b. Name of Medicaid Financial Officer making these assurances:

Greta Rymal

c. Telephone Number:

(512) 424-6919

d. E-mail:

Greta.Rymal@hhsc.state.tx.us

e. The State is choosing to report waiver expenditures based on

- (●) **date of payment.**
- ( ) **date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.**

Section D: Cost-Effectiveness

Part I: State Completion Section

B. Expedited or Comprehensive Test

To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

b. ☐ The State provides additional services under 1915(b)(3) authority.

c. ☐ The State makes enhanced payments to contractors or providers.

d. ☐ The State uses a sole-source procurement process to procure State Plan services under this waiver.

e. ☐ The State uses a sole-source procurement process to procure State Plan services under this waiver. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete ***Appendix D3***
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB.*

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

Section D: Cost-Effectiveness

Part I: State Completion Section

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in A.I.b.

a. ☐ **MCO**

b. ☐ **PIHP**

c. ☐ **PAHP**
d. ☑ **PCCM**
e. ☐ **Other**

Please describe:

TMWP services are available to Medicaid beneficiaries who receive medical services through Medicaid FFS; are able, or have a caregiver who is able, to respond actively to health information and care coordination activities; and who are identified by HHSC and the TMWP contractor as being high-cost and/or high-risk due to chronic illness or condition. The TMWP contractor receives a per-member-per-month fee for enrollees who opt-in to waiver services, which does not include a component for medical claims. TMWP enrollees receive medical services under the traditional FFS Medicaid program, and not under the waiver itself. At the direction of CMS during the last renewal application, HHSC changed the TMWP delivery system from a Prepaid Ambulatory Health Plan (PAHP) to a PCCM and FFS Selective Contracting system.

Section D: Cost-Effectiveness

Part I: State Completion Section

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a. ☐ **Management fees are expected to be paid under this waiver.**

The management fees were calculated as follows.

1. ☐ **Year 1: $** _____ **per member per month fee.**
2. ☐ **Year 2: $** _____ **per member per month fee.**
3. ☐ **Year 3: $** _____ **per member per month fee.**
4. ☐ **Year 4: $** _____ **per member per month fee.**

b. ☐ **Enhanced fee for primary care services.**

Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c. ☐ **Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization.** Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost.

d. ☑ **Other reimbursement method/amount.**

$ _____

Please explain the State's rationale for determining this method or amount.

The reason the state did not enter a dollar amount in the box provided for reimbursement method/amount is because the state pays the contractor based on the level of care for each member. The state pays the following PMPM rates for the different levels:

Client Stratification Level and PMPM Fixed Rate
Level 1 $188.87
Level 2 $110.20
Level 3 $68.07

The state negotiated the PMPM rate at the time of the initial contract with the vendor.

Section D: Cost-Effectiveness

Part I: State Completion Section

E. Member Months

Please mark all that apply.

a. ☑ [Required] Population in the base year and R1 and R2 data is the population under the waiver.

b. ☐ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*

c. ☑ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
On March 1, 2012, Texas expanded its Medicaid Managed Care program to all areas of the state. The adult disabled and blind population were mandated into either the STAR+PLUS program, or into a STAR program for the rural service delivery areas. Therefore, the TMWP lost most of its adult population. Furthermore, as a result, the contractor increased focus on the child population remaining in fee- for-service, including the dual eligible children in Department of Family and Protective Services (DFPS) conservatorship ineligible for STAR Health, to participate in the program. The new child population increased total population (member months). The dual eligible children under the age of 21 will not increase the PMPM as their average costs are not expected to differ from the existing active members. This program is capped at 36,000 active members per quarter. When STAR Kids goes into effect on November 1, 2016, approximately 92 percent of the TMWP eligible pool and clients serviced will transition to STAR Kids and will receive coordination through a STAR Kids managed care organization. HHSC proposes to align the cost effectiveness calculations with the remaining FFS populations eligible for TMWP after STAR Kids goes into effect. On December 1, 2106, the Adaption Assistance and Permanency Care Assistance population has been added to the waiver, thus the increase in member months from the previous amendment.

d. ☑ [Required] Explain any other variance in eligible member months from BY/R1 to P2:
As the PCCM identifies and engages clients, it is the expectation that many individuals will remain in the program over time while new individuals are identified and enrolled as active member spaces become available.

e. ☑ [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:
The State is using the most recent complete program period (April 2014 through March 2015).

Appendix D1 – Member Months

Section D: Cost-Effectiveness

Part I: State Completion Section

F. Appendix D2.S - Services in Actual Waiver Cost

For Conversion or Renewal Waivers:

a. ☐ **[Required] Explain if different services are included in the Actual Waiver Cost from the previous period in Appendix D3 than for the upcoming waiver period in Appendix D5.**
Explain the differences here and how the adjustments were made on Appendix D5:

b. ☐ **[Required] Explain the exclusion of any services from the cost-effectiveness analysis.**
For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

Appendix D2.S: Services in Waiver Cost

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Lab or Radiology (Includes Psych)	☐	☐	☑	☐	☐	☐	☐
SSI Dual Eligible under 21	☐	☐	☑	☐	☐	☐	☐
Rural Health Clinic	☐	☐	☑	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
Prescribed Drugs	☐	☐	☑	☐	☐	☐	☐
Other Practitioners (Includes Psych)	☐	☐	☑	☐	☐	☐	☐
dental services	☐	☐	☑	☐	☐	☐	☐
Fees to Contractor for Texas Medicaid Health Management Services	☐	☐	☑	☐	☐	☐	☐
Tribal 638	☐	☐	☑	☐	☐	☐	☐
Family Planning	☐	☐	☑	☐	☐	☐	☐
Mental Health Facility	☐	☐	☑	☐	☐	☐	☐
Physician Services (includes Psych)	☐	☐	☑	☐	☐	☐	☐
IHS Inpatient	☐	☐	☑	☐	☐	☐	☐
Sterilizations	☐	☐	☑	☐	☐	☐	☐
Skilled Nursing Home	☐	☐	☑	☐	☐	☐	☐
ICF-MR Public	☐	☐	☑	☐	☐	☐	☐
FQHC	☐	☐	☑	☐	☐	☐	☐
Other Care Services	☐	☐	☑	☐	☐	☐	☐
IHS Outpatient	☐	☐	☑	☐	☐	☐	☐
Home Health Services	☐	☐	☑	☐	☐	☐	☐
ICF-MR Private	☐	☐	☑	☐	☐	☐	☐
Clinic Services	☐	☐	☑	☐	☐	☐	☐
EPSDT Screening	☐	☐	☑	☐	☐	☐	☐
ICF-Other	☐	☐	☑	☐	☐	☐	☐

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Inpatient Hospital (includes Psych)	☐	☐	☑	☐	☐	☐	☐
Outpatient Hospital (Includes Psych)	☐	☐	☑	☐	☐	☐	☐

Section D: Cost-Effectiveness

Part I: State Completion Section

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*
The allocation method for either initial or renewal waivers is explained below:

- **a.** ☑ **The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees***Note: this is appropriate for MCO/PCCM programs.*
- **b.** ☐ **The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled.***Note: this is appropriate for statewide PIHP/PAHP programs.*
- **c.** ☑ **Other**

  Please explain:

  The State allocates the administrative costs to the PCCM program based upon the number of waiver enrollees as a percentage of the total Medicaid enrollees, rather than based upon the program cost as a percentage of the total Medicaid budget for consistency's sake and to eliminate the chance of the same cost being claimed in two different waivers. It is in the best interest of the Medicaid program to apply the same methodology for allocating administrative costs across all waivers. The waiver includes cost allocations for the Actuarial contract, State staff, and claims administrator cost.

Appendix D2.A: Administration in Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

H. Appendix D3 - Actual Waiver Cost

- **a.** ☐ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.
- **b.** ☑ **The State is including voluntary populations in the waiver.**

  Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

  The concept of selection bias no longer impacts cost estimates for this mature waiver program. Any selection bias demonstrated by the voluntary population is represented in the actual costs reported for the retrospective waiver period and is being used to project costs for the prospective waiver period.
- **c.** ☐ **Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage:** Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required.

The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1. ☐ **The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.**
2. ☐ **The State provides stop/loss protection**

   Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

d. ☐ **Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:**

1. ☐ **[For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program.** The costs associated with any bonus arrangements must be accounted for in the capitated costs (Column D of Appendix D3 Actual Waiver Cost). Regular State Plan service capitated adjustments would apply.

   Document

   i. **Document the criteria for awarding the incentive payments.**
   ii. **Document the method for calculating incentives/bonuses, and**
   iii. **Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.**

2. ☐ **For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (Column G of Appendix D3 Actual Waiver Cost).**). For PCCM providers, the amount listed should match information provided in D.I.D Reimbursement of Providers. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (See D.I.I.e and D.I.J.e)

   Document:

   i. **Document the criteria for awarding the incentive payments.**
   ii. **Document the method for calculating incentives/bonuses, and**
   iii. **Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.**

Appendix D3 – Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (1 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (2 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (3 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (4 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (5 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (6 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (7 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (8 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (1 of 5)

a. State Plan Services Trend Adjustment – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **. This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. ☑ **[Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (i.e., trending from 1999 to present).**

   The actual trend rate used is: 5.00

   Please document how that trend was calculated:

   The Bureau of Labor Statistics has estimated a CPI index for Medical Services of 5.83% for the Dallas area, and 4.16% for the Houston area for the period of June 2014 to June 2015. Based on this, a 5% trend rate should be justified for our State Plan services.

2. ☑ **[Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations)** *(i.e., trending from present into the future).*

   i. ☐ **State historical cost increases.**

   Please indicate the years on which the rates are based: base years. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

   ii. ☑ **National or regional factors that are predictive of this waiver's future costs.**

   Please indicate the services and indicators used. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

   The Bureau of Labor Statistics has estimated a CPI index for Medical Services of 5.83% for the Dallas area, and 4.16% for the Houston area for the period of June 2014 to June 2015. Based on this, a 5% trend rate should be justified for our State Plan services.

3. ☐ **The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase.**

   Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

   i. **Please indicate the years on which the utilization rate was based (if calculated separately only).**
   ii. **Please document how the utilization did not duplicate separate cost increase trends.**

Appendix D4 – Adjustments in Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (2 of 5)

b. State Plan Services Programmatic/Policy/Pricing Change Adjustment: This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1. ☐ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2. ☑ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

i. ☐ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.

Please list the changes.

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).

PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.

Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.

PMPM size of adjustment

D. ☐ Determine adjustment for Medicare Part D dual eligibles.

E. ☐ Other:

Please describe

ii. ☐ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii. ☐ Changes brought about by legal action:

Please list the changes.

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.
PMPM size of adjustment

D. ☐ Other
Please describe

iv. ☐ Changes in legislation.

Please list the changes.

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA
PMPM size of adjustment

D. ☐ Other
Please describe

v. ☑ Other

Please describe:
When STAR Kids goes into effect 11/1/16, approximately 92% of the TWMP eligible pool and clients served will transition to STAR Kids and will receive service coordination through a STAR Kids managed care organization. HHSC proposes to align the cost effectiveness calculations with the remaining FFS populations eligible for TMWP after STAR Kids goes into effect.

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.
PMPM size of adjustment

D. ☑ Other
Please describe
With this new amendment, we are now adding the Adoption Assistance and Permanency Care Assistance population which have a lower costs PMPM resulting in an overall lower PMPM. The effect of the change is calculated by taking the PMPM of the new population divided by the PMPM costs calculated using the original cost information and updated caseload:
(1148.25/1568.17) -1 = -26.78%

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c. Administrative Cost Adjustment: This adjustment accounts for changes in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1. ☐ No adjustment was necessary and no change is anticipated.

2. ☑ An administrative adjustment was made.

i. ☐ Administrative functions will change in the period between the beginning of P1 and the end of P2.
Please describe:

ii. ☑ Cost increases were accounted for.

A. ☐ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B. ☐ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C. ☐ State Historical State Administrative Inflation. THe actual trend rate used is PMPM size of adjustment

Please describe:

D. ☑ Other
Please describe:

HHSC, from historical experience has used an administrative trend rate of 2.00% pmpm. This would include price, units of service, technology, and other factors, but not increases in population. For trending from R2 to P1, there were 21 months from the mid-point of the 12 months of data in R2 to the mid-point of P1= ((1.02)^(21/12)) -1 = 3.53%. For P1 to P2, we use 2.0%.

iii. ☐ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate.
Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate.

Please indicate the years on which the rates are based: base years

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate.
Please indicate the State Plan Service trend rate from Section D.I.J.a. above

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d. 1915(b)(3) Adjustment: The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in ***Section D.I.H.a*** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1. ☐ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (i.e., trending from 1999 to present).
The actual documented trend is:

Please provide documentation.

2. ☐ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (i.e., trending from present into the future), the State must use the lower of State historical 1915(b)(3) trend or State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i.

A. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years

2. Please provide documentation.

B. State Plan Service trend

Please indicate the State Plan Service trend rate from Section D.I.J.a. above

e. Incentives (not in capitated payment) Trend Adjustment: If the State marked **Section D.I.H.d ,** then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from Section D.I.I.a
2. List the Incentive trend rate by MEG if different from Section D.I.I.a
3. Explain any differences:

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p. *Other adjustments* including but not limited to federal government changes.

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - Excess payments addressed through transition periods should not be included in the 1915(b) cost effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only) ***: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

  Basis and Method:

  1. Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total

Medicaid population **which includes accounting for Part D dual eligibles**. Please account for this adjustment in **Appendix D5.**

2. ☐ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS **or Part D for the dual eligibles**.
3. ☐ Other

Please describe:

1. ☐ No adjustment was made.

2. ☑ This adjustment was made. This adjustment must be mathematically accounted for in Appendix D5.

Please describe
HHSC changed the TMWP delivery system from a Prepaid Ambulatory Health Plan (PAHP) to a PCCM and FFS Selective Contracting system, therefore there are no longer 1915(b)(3) costs in this waiver, thus a (100.00) percent adjustment was made to remove the cost from R1 and R2.

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K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in Section D.I.I and D.I.J above.

See referenced sections for any required explanations.
Appendix D5 – Waiver Cost Projection

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L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in Section D.I.E. above.

See referenced sections for any required explanations.
Appendix D6 – RO Targets

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M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

Only trend adjustments.

1. Please explain caseload changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in Section D.I.E.c & d:

   For the actual caseload in the waiver, fluctuation in program enrollment is attributed to changes in Medicaid enrollment (i.e., moving to a geographic area served by a managed care organization) or by enrollment initiatives performed by the PCCM.
2. Please explain unit cost changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in Section D.I.I and D.I.J:

   See referenced sections for any required explanations.

3. Please explain utilization changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in Section D.I.I and D.I.J:

See referenced sections for any required explanations.

b. Please note any other principal factors contributing to the overall annualized rate of change in Appendix D7 Column I.

N/A

Appendix D7 - Summary